

**MARKET CONDUCT EXAMINATION REPORT
PROMPT PAY**

of

COVENTRY HEALTH CARE of DELAWARE, INC.

as of

June 30, 2006

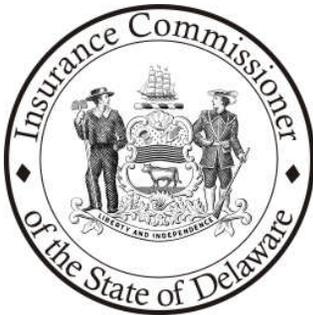
I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

COVENTRY HEALTH CARE OF DELAWARE, INC.

is a true and correct copy of the document filed with this Department.

ATTEST BY: *Antoinette Handy*

DATE: 15 MAY 2008



In Witness Whereof, I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 15TH DAY OF MAY 2008.

Matthew Denn

Insurance Commissioner

REPORT ON MARKET CONDUCT EXAMINATION
OF THE
COVENTRY HEALTH CARE OF DELAWARE, INC.
AS OF
JUNE 30, 2006

The above captioned Report was completed by examiners of the Delaware Insurance Department.

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.

A handwritten signature in black ink, appearing to read "Matt Denn", written over a horizontal line.

MATTHEW DENN
INSURANCE COMMISSIONER

DATED this 15TH day of MAY, 2008.

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May 8, 2007

Honorable Matthew Denn
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.723, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

Coventry Health Care of Delaware, Inc.

hereinafter referred to as the "Company." The Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services

This report is as of June 30, 2006. It covers the period from January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

EXECUTIVE SUMMARY

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the seven (7) examination standards authorized by Certificate of Examination Authority Number 06.724. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair, and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80].

The principal focus for this examination was compliance with the Delaware insurance laws related to prompt, fair and equitable settlement of claims for health care services. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310, the timely, fair, and equitable payment of clean claims. The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

Prompt Payment Standards 1-7: The examiners found six (6) areas of concern resulting in failure of the Company to comply with Standards 1, 2, 3, 4 and 6. The issues identified were:

- The Company definition of a clean claim does not comply with the definition of a clean claim as defined in 18 Del. Admin. Code 1310 § 4.
- In some instances the Company is denying claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance Del. Admin. Code 1310 § 4.7.
- In some instances, clean claims were not adjudicated within 30 calendar days of receipt, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.
- In some instances in network claims were incorrectly denied on original submission as being out of network, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.
- In some instances emergency room claims which should not require preauthorization were incorrectly denied as unauthorized, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.
- In some instances, claims for which additional information was requested were not adjudicated timely following the receipt of requested information, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.2.

HISTORY AND PROFILE

The Company is a managed care organization that was incorporated in the state of Delaware and was granted a Certificate of Authority to operate as a health maintenance organization on October 6, 1986, as Principal Health Care, Inc.

Physicians Health Plan of Delaware, Ltd., a Delaware corporation, was incorporated on May 29, 1985, by Delaware physicians in order to establish and operate an IPA model HMO. On October 14, 1986, the company changed its name to Health Plan of Delaware, Ltd. The company's Certificate of Authority was granted by the State of Delaware on November 17, 1986.

In 1988, Principal Health Care, Inc. ("PHC") acquired Health Plan of Delaware, Ltd. and, on December 15, 1988, changed that company's name to Principal Health Care of Delaware, Inc. ("CHCD"). PHC was a wholly owned subsidiary of Principal Holding Company ("Principal Holding"), which was wholly owned by Principal Life Insurance Company, formally Principal Mutual Life Insurance Company ("Principal Life"). The State of Maryland granted CHCD a Certificate of Authority on December 1, 1996.

On April 1, 1998, the Delaware Department of Insurance approved the acquisition of Principal Health Care of Delaware, Inc. by Coventry Health Care, Inc. (CHC), as the result of a business combination among Principal Life, Principal Holding, PHC and the publicly held Coventry Corporation. Under the combination, Coventry Health Care, Inc. was formed on December 17, 1997 by Coventry Corporation (60% shareholder) and Principal Health Care, Inc. (40% shareholder).

Also effective April 1, 1998, Coventry Corporation was merged into a newly formed subsidiary of Coventry Health Care, Inc. CHC became the publicly held company. PHC contributed all of the outstanding stock of Principal Health Care of Delaware, Inc. (along with other HMOs it owned) to CHC in exchange for 40% of the outstanding stock of CHC.

Principal Health Care of Delaware, Inc. changed its name to Coventry Health Care of Delaware, Inc. ("CHCD") on October 4, 1999. CHCD is a for-profit, wholly owned subsidiary of Coventry Health Care, Inc. of Bethesda, Maryland.

Company is only licensed in Delaware and Maryland and does not do business in the individual market.

METHODOLOGY

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC methodology.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were measured using tests designed to adequately measure how the examinee met each standard. Each standard tested is described and the result of testing is provided under the appropriate standard. Only standards tested are shown in this report.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

The following sections are covered in a full scope market conduct examination. They are listed here to clarify that this exam was limited to the claims area only.

- A. COMPANY OPERATIONS/MANAGEMENT- not addressed on this exam
- B. COMPLAINTS/GRIEVANCES-not addressed on this exam
- C. MARKETING AND SALES- not addressed on this exam

- D. NETWORK ADEQUACY- not addressed on this exam
- E. PRODUCER LICENSING-not addressed on this exam
- F. POLICYHOLDER SERVICE-not addressed on this exam
- G. UNDERWRITING AND RATING-not addressed on this exam
- H. CLAIMS

Comments: The examiners reviewed six separate claims samples. All of the samples selected were random samples of specific populations. The six samples selected for review are as follows:

- Sample 1. One-hundred-fifteen claims from a population of 265,167 paid claims adjudicated by the Company within the examination period.
- Sample 2. One hundred-fifteen claims from a population of 65,756 denied claims adjudicated by the Company.
- Sample 3. One hundred behavioral health claims from a population of 6,243 paid claims adjudicated by United Behavioral Health (UBH) within the examination period.
- Sample 4. One hundred behavioral health claims from a population of 2,520 denied claims adjudicated by UBH within the examination period.
- Sample 5. One hundred-fifteen radiology claims from a population of 2,984 paid claims adjudicated by MedSolutions (MSI) within the examination period.
- Sample 6. One hundred-fifteen radiology claims from a population of 1,183 denied claims adjudicated by MSI within the examination period.

The evaluation of standards in this business area is based on Company responses to information requested by the examiners, discussions with the Company's staff, and the sample review of claim files. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment complies with applicable statutes, rules, and regulations.

Services provided to the insureds of the Company do not typically result in a claim by the recipient of care as is usually seen in an indemnity scenario. Claims to the Company usually arise from the provider who delivers services to an insured of the Company.

The following Standards were developed to test compliance with Delaware statutes, rules, and regulations.

Prompt Payment Standard 1

The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.

18 Del. Admin. Code 1310 § 4.0

Comments: This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" complies with 18 Del. Admin. Code 1310 § 4.0. Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, and internal communications of the Company, UBH, and MSI. The examiners also interviewed claims personnel.

Results: FAIL

Observation: The Company defines a clean claim as "A clean claim shall mean a claim that has no defect or impropriety (including lack of any required substantiating documentation) or particular circumstance requiring special treatment that substantially prevents timely payments

from being made on the claim. This means that any claim requiring information that must be obtained from an external source for correct processing makes the claim incomplete.”

The Company’s definition of a clean claim does not comply with the definition of a clean claim as defined in 18 Del. Admin. Code 1310 § 4.

***Recommendations:* It is recommended that the Company identify clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.0.**

Prompt Payment Standard 2

The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included.

18 Del. Admin. Code 1310 § 4.7

Comments: This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7. Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, UBH, and MSI. The examiners also interviewed claims personnel.

Results: FAIL

Observation: Review of all selected samples indicated that four (4) claims out of 100 tested from Sample 4, that met the state’s definition of a clean claim, were denied with reason code 638 (Mental Health/Substance Abuse not covered. Your plan does not cover Mental Health and/or substance abuse services when they are provided in connection with conditions not classified in the Diagnostic and Statistical Manual of the American Psychiatric Association.) However, the diagnoses listed on the claim forms were recognized and listed in the manual referenced by the Company. The claims were not processed in accordance with the requirements of 18 Del. Admin. Code 1310. No errors were revealed in Samples 1, 2, 3, 5, or 6.

***Recommendations:* It is recommended that the Company process clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.7.**

Prompt Payment Standard 3

<p>The Company’s clean claim processing is timely and in compliance with applicable statutes, rules and regulations.</p> <p>18 <u>Del. C.</u> § 2304, 18 <u>Del. Admin. Code</u> 1310 § 6.0 and 7.0</p>
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Comments: This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0 et al which requires adjudication within 30 days and 18 Del. Admin. Code 1310 § 7.0, which states “Within a 36 month period, three instances of a carrier’s failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304.”

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

Results: FAIL

Observation: Review of all selected samples indicated that there were 38 errors, in which claims meeting the state's definition of a clean claim were adjudicated in an untimely manner. Those errors are outlined below:

1. Four (4) of the 115 claims from Sample 1;
2. Eight (8) of the 115 claims from Sample 2;
3. Five (5) of the 100 claims from Sample 3;
4. Six (6) of the 100 claims from Sample 4;
5. Ten (10) of the 115 claims from Sample 5; and
6. Five (5) of the 115 claims from Sample 6.

The number of non-compliant instances exceeds the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304

***Recommendations:* It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department.**

Prompt Payment Standard 4

Proper payment is made on clean claims.

18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2

Comments: This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

Results: FAIL

Observation: Review of the selected samples indicated fourteen (14) errors. In 13 instances claims were incorrectly denied on original submission as out of network provider when in fact provider was an in network provider. Those errors are outlined below:

1. One (1) of the 100 claims from Sample 3;
2. Eleven (11) of the 100 claims from Sample 4; and
3. One (1) of the 115 claims from Sample 6.

In addition, the review of Sample 2 indicated one (1) claim of 115 tested was an emergency room claim that included a surgical procedure and was incorrectly denied for no authorization. The claim was overturned on appeal.

Further inquiry of the Company indicated the Company was denying all emergency room claims that included a surgical procedure and had a 100% overturn rate on appeal. The Company advised the examiners that guidelines have been implemented to ensure proper adjudication of this type of emergency room claim. However, the Company did not provide documentation of either the guidelines or the date that such guidelines were implemented

The above practices appear to constitute non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

The review of Samples 1, 2, and 5 revealed no errors.

Recommendations: It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated accurately and according to the requirements of 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2. The Company should report to the Department its findings and any modifications to its systems and procedures implemented to assure ongoing compliance.

Prompt Payment Standard 5

The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.

18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3

Comments: This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3.

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

Results: PASS

Observation: Review of the sample of claims indicate the Company, UBH and MSI are sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

Prompt Payment Standard 6

The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules.

18 Del. Admin. Code 1310 § 6.1.4, 6.2 and 6.3

Comments: This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 § 6.1.4 states “if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.” 18 Del. Admin. Code 1310 § 6.2 states in part, “A carrier who requests information under this subsection shall take action... within 15 days of receiving properly requested information.” 18 Del. Admin. Code 1310 § 6.3 limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

Results: FAIL

Observation: Review of all selected samples indicated 16 errors in which claims were not processed within 15 days of receipt of the information requested by the Company, resulting in non-compliance with the requirement of 18 Del. Admin. Code 1310 § 6.2. Those 16 errors are outlined below.

1. One (1) of the 115 claims from Sample 1;
2. Eight (8) of the 115 claims from Sample 2;
3. Four (4) of the 100 claims from Sample 4; and
4. Three (3) of the 115 claims from Sample 6.

Review of Sample 3 and 5 revealed no errors.

The number of non-compliant instances exceeds the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304.

When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. If the Company receives additional information, the claim is given a new claim number and re-adjudicated based on the information received. This is considered a “soft denial.” The Company’s stated procedures are to re-adjudicate claims for which requested information was submitted within 15 days of the receipt of that additional information.

Recommendations: It is recommended that the Company adjudicate claims timely following the receipt of requested information according to the requirements of 18 Del. Admin. Code 1310 § 6.2.

Prompt Payment Standard 7

The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations.

18 Del. Admin. Code 1310 § 8.0

Comments: This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

Results: PASS

Observation: No interest payments on claims have been ordered to date.

SUMMARY

The Company is a Delaware domiciled health insurer that provides health care coverage in the commercial market.

These examinations focused on compliance with Delaware prompt pay laws and regulations.

Recommendations have been made to address the areas of concern noted during the examination.

These are summarized below.

LIST OF RECOMMENDATIONS

It is recommended that the Company identify clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.0. (p.9)

It is recommended that the Company process clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.7. (p.10)

It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department. (p.11)

It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated accurately and according to the requirements of 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2. The Company should report to the Department its findings and any modifications to its systems and procedures implemented to assure ongoing compliance. (p.13)

It is recommended that when additional information is requested the Company adjudicate the claims timely following the receipt of requested information according to the requirements of 18 Del. Admin. Code 1310 § 6.2. (p.16)

CONCLUSION

The examination was conducted by the undersigned and respectfully submitted,

A handwritten signature in black ink, appearing to read "Heidi R. Pappas", written in a cursive style. The signature is positioned above a solid horizontal line.

Market Conduct Examiner-in-Charge
Delaware Insurance Department